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In The
Supreme Court of the United States

ALBERTO R. GONZALES,
ATTORNEY GENERAL, *et al.*,

Petitioners,

v.

STATE OF OREGON, *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF AMERICAN COLLEGE OF LEGAL MEDICINE, AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Whether the Attorney General has the unfettered right under the Controlled Substances Act to decide what is a legitimate medical purpose or use for determining parameters for medical intervention by physicians in the State of Oregon.

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INTEREST OF *AMICUS CURIAE*

The American College of Legal Medicine ("ACLM") respectfully submits this brief as an *Amicus Curiae* pursuant to Rule 37 of the Rules of the Supreme Court of the United States. ACLM supports respondents in this case. ACLM has received the consent of all parties to submit this brief pursuant to the applicable rules of this Court.[1]

The ACLM has been in existence now for 45 years and is an educational, non-profit organization with nearly 1400 members. It is the only organization within the United States the majority of whose members possess degrees in medicine and in law. Its membership also consists of attorneys, physicians, nurses, persons in health care administration, in government service and those who hold full time academic positions in health care and in health care law. The ACLM is also part of the network of organizations worldwide whose members possess degrees, background, and interest in the fields of medicine, forensic science, and law or jurisprudence.

The mission of the ACLM is to educate, train and advance dialogue and discussion for those who have a sustained interest in issues at the crossroads of law, medicine, and health care delivery. This includes promoting the administration of justice and assisting jurists in deciding issues, such as those presented in this case.

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[1] Petitioners and respondents have consented to the filing of this brief in letters filed with the clerk. No counsel for a party authored this brief in whole or in part. No persons or entities other than the *amicus* made a monetary contribution to the preparation or submission of this brief.

SUMMARY OF ARGUMENT

The Attorney General, in a November 9, 2001 directive, declared that the use of controlled substances under the Oregon Death with Dignity Act was not a "legitimate medical purpose." *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1079 (D. Or. 2002) (quoting 66 Fed. Reg. 56,607 (Nov. 9, 2001)). This interpretation was promulgated in the Federal Register without prior notice to or comments by interested parties. *Oregon v. Ashcroft*, 368 F.3d 1118, 1130 (9th Cir. 2004). The Attorney General's controversial interpretation was based on lay opinion and a memorandum from the Justice Department entitled, *Whether Physician-Assisted Suicide Serves a "Legitimate Medical Purpose" Under The Drug Enforcement Administration's Regulations Implementing the Controlled Substances Act* (June 27, 2001) ("OLC Opinion"). The Attorney General's statement represented a 180-degree shift in Drug Enforcement Administration ("DEA") policy and stood contrary to former Attorney General Janet Reno's position. *Oregon v. Ashcroft*, 368 F.3d at 1123. The Ninth Circuit held that, "the Attorney General has no specialized expertise in the field of medicine and that he imposes a sweeping and unpersuasive interpretation of the CSA . . . " *Id.* at 1130. This interpretation was made unilaterally and without the assistance of the Department of Health and Human Services ("HHS"), as required by the Controlled Substances Act ("CSA"). 21 U.S.C. § 811(b) (2005). The Ninth Circuit ruled that Attorney General Ashcroft had overstepped his bounds by making this determination and upheld the issuance of an injunction against the administration. *Oregon v. Ashcroft*, 368 F.3d at 1131.

We respectfully point out that the Attorney General's attempt to define "legitimate medical purpose" constitutes

a unilateral, uninformed, and politically-motivated action. The Attorney General does not have the authority, under the CSA, to make this determination. This determination is left to the states and the Secretary of HHS, informed by medical expertise. The Attorney General also failed to properly evaluate physician-assisted suicide under the "public interest" standard of the CSA. The Attorney General further failed to give due deference to input from the Oregon State Medical Board in assessing the five factors under the "public interest" standard of the CSA.

Instead of consulting the proper authority, the Attorney General has unilaterally determined what constitutes a "legitimate medical purpose" under the CSA. The federal government, however, has limited power under the CSA in making determinations of medical standards. Traditionally, states have regulated the practice of medicine as part of the police powers of the state. Allowing the enforcement of the Attorney General's view would also violate the Tenth Amendment, nullify this Court's opinion in *Washington v. Glucksberg*, 521 U.S. 702 (1997), and become a Damoclean sword unnecessarily held over the practice of medicine. The Attorney General's directive serves to invalidate Oregon's determination of a valid practice of medicine. If upheld, the opinion of a single administrative official could prevent physicians and patients from ensuring a pain-free and dignified end of life.

ARGUMENT

I. THE CONTROLLED SUBSTANCES ACT DOES NOT GIVE THE ATTORNEY GENERAL THE POWER TO DETERMINE WHAT IS A LEGITIMATE MEDICAL PURPOSE

Under the CSA, controlled substances are scheduled according to whether they have a "currently accepted medical use" or "no currently accepted medical use," with varying levels of restrictions. 21 U.S.C. § 812(b) (2005). The Act specifically delineates the manner in which drugs are scheduled and "accepted medical use" is determined. Integral to these determinations is the input of the Secretary of HHS. The Secretary's opinion is not simply advisory with respect to scheduling drugs, but binding. 21 U.S.C. § 811(b). The CSA states:

> [T]he recommendations of the Secretary to the Attorney General *shall be binding* on the Attorney General as to such *scientific and medical matters*, and if the Secretary recommends that a drug or other substance not be controlled, the Attorney General shall not control the drug or other substance.

Id. [emphasis added.]

Thus, the Attorney General can only make a determination of what is and is not a currently accepted medical use *based on a scientific and medical evaluation from the Secretary of HHS*. The Secretary must also include recommendations regarding where a substance should be scheduled. The recommendations of HHS are binding on the Attorney General as to scientific and medical matters, including where a drug is scheduled and whether or not a drug ought to be controlled.

The importance of the Secretary's input was acknowledged by this Court in its recent decision in *Gonzales v. Raich*, ___ U.S. ___, 125 S.Ct. 2195 (2005), where the Court noted that, under the CSA, the Attorney General must consult with the Secretary before updating and modifying the schedules of controlled substances. *Id.* at 2204. In *Gonzales*, this Court also noted that even Congress' decision to classify marijuana was based, in part, on the recommendation of the Department of Health and Human Services (then, the Department of Health, Education, and Welfare). *Id.*

The CSA does not give the Attorney General the authority to declare, *sua sponte*, what is and is not a currently accepted medical use. Instead, the Attorney General must defer to the expert medical judgment of HHS, embodied in a "scientific and medical evaluation." The history of the CSA highlights the legislative intent to preclude the Attorney General from making medical decisions. In a monograph of the National Institute on Drug Abuse, David E. Joranson states, "When Congress adopted the final version of the CSA in October 1970, the Secretary of Health, Education, and Welfare, and not the Attorney General, had been given the responsibility for making medical and scientific decisions concerning drug control." David E. Joranson, *Guiding Principles of International and Federal Laws Pertaining to Medical Use and Diversion of Controlled Substances*, 131 NIDA Research Monograph at 14 (1993), *available at* http://www.medsch.wisc.edu/painpolicy/publicat/93nida.htm. As Congressman Paul Rogers of the House Subcommittee on Health and the Environment stated:

> As Members may recall, the scientific and medical community of this nation were greatly upset

> over the fact that scientific and medical decisions in the Senate bill were centered in the Department of Justice, with the Attorney General having responsibility to make scientific and medical determinations which were not in the competency of the Department, and admittedly so. We have changed that so that the Department of Health, Education and Welfare will determine scientific and medical decisions. This is a most important change in the whole approach as it came from the Senate.

116 Cong. Rec. 33304 (Sept. 23, 1970).

The Attorney General's discretion is limited under the CSA. The Attorney General may determine whether to schedule a derivative drug in the same schedule or a higher numerical schedule than its immediate precursor. 21 U.S.C. § 811(e) (2005). And, if there is an imminent hazard to public safety, the Attorney General may move a controlled substance to Schedule I (no currently accepted medical use) for no more than eighteen months. 21 U.S.C. § 811(h) (2005). Neither of these decisions involves a determination of what is or is not a legitimate medical use.

The folly of the Attorney General's presumption that he can determine what is and is not a legitimate medical purpose for an approved drug is further illustrated by the mistaken assertions in his brief. The Attorney General argues that using controlled substances according to the Oregon Death with Dignity Act is not a legitimate medical purpose because it "does not aim to preserve the patient's health or to cure, alleviate, prevent, or 'treat' the disease or its symptoms in the patient." Petitioner's Brief at 19. The Attorney General thus confuses "legitimate medical purpose" with "therapeutic." Many legitimate medical interventions are not therapeutic. For example, the FDA

has approved the prescription use of botulism injection "to temporarily improve the appearance of moderate to severe frown lines between the eyebrows." *FDA Approves Botox to Treat Frown Lines*, FDA Talk Paper (U.S. Food and Drug Admin.), April 15, 2002, *available at* http://www.fda.gov/bbs/topics/ANSWERS/2002/ANS01147.html. This is a legitimate medical purpose, although its objective is cosmetic rather than to cure, alleviate, prevent, or treat disease. Indeed, the Attorney General's position would place the entire field of cosmetic surgery outside the legitimate practice of medicine, thereby making surgeons who employed controlled substances in the course of their cosmetic practice felons and at risk of losing their DEA registrations.

This same confusion is evident in the Attorney General's reliance on the fact that the Centers for Medicare and Medicaid Services of the Department of Health and Human Services has determined that physician-assisted suicide is not eligible for reimbursement under Medicare or Medicaid because it is "not reasonable and necessary for the diagnosis and treatment of disease or injury." Petitioner's Brief at 8, 47, n.18. Numerous legitimate medical interventions are not reimbursed under Medicare or Medicaid, including outpatient prescription drugs and routine physical checkups. 42 U.S.C. § 1395y.

A. The Attorney General Improperly Invoked the "Public Interest" Evaluation Under 21 U.S.C. § 824(a)

In 1984, the United States Congress amended the CSA by allowing the Attorney General to revoke licenses when registrants acted in a manner inconsistent with the "public interest." 21 U.S.C. § 824(a)(4) (2005). The Attorney

General, in this case, has attempted to use this power to prevent assisted suicide. In his 2001 opinion, the Attorney General warned that "administering federally controlled substances to assist suicide may 'render [a physician's] registration . . . inconsistent with the public interest and therefore subject to possible suspension or revocation under 21 U.S.C. § 824(a)(4).'" *Oregon v. Ashcroft*, 192 F. Supp. 2d at 1079. As noted by the Ninth Circuit, the Attorney General impermissibly applied the "public interest" revocation standard by failing to properly evaluate the registrant's actions. *Oregon v. Ashcroft*, 368 F.3d at 1130.

The determination that a registrant's actions are "against the public interest" requires an assessment of five factors outlined in 21 U.S.C. § 823(f). *Trawick v. Drug Enforcement Admin.*, 861 F.2d 72, 75 (4th Cir. 1988). Paramount among these factors is the recommendation of the presiding state medical board. *Oregon v. Ashcroft*, 368 F.3d at 1129. The legislative history of this amendment stressed this fact, stating that "the Attorney General must 'continue to give deference to the opinions of the State licensing authorities,' as their recommendations are the 'first of the factors to be considered.'" *Id.* (quoting S. Rep. No. 98-225, at 267 (1983), *reprinted in* 1984 U.S.C.C.A.N. 3182, 3449.) However, "[i]t is undisputed that the Attorney General made no effort to solicit input from the State of Oregon before issuing his directive." *Id.* Accordingly, the Attorney General cannot assert that assisting suicide with controlled substances is against the public interest in Oregon because he has failed to perform the proper five-factor analysis necessary for making this conclusion.

In addition to ignoring the proper interpretation of the "public interest", the Attorney General's directive attempts

improperly to expand the scope of the CSA and the 1984 amendment. The CSA was enacted specifically to deal with "problems associated with drug abuse and addiction." *Id.* at 1128. The Attorney General's attempt to bar physician-assisted suicide is outside the scope of the act as "assisted suicide is not a form of drug abuse that Congress intended the CSA to cover." *Id.* at 1125.

The 1984 amendment similarly targets criminal diversion and abuse of drugs. The Attorney General's use of the amendment to bar assisted suicide is, again, beyond the scope of the act. The Fourth Circuit has held that 21 U.S.C. § 824(a) and the "public interest" standard were promulgated specifically to thwart criminal diversion of drugs. *Trawick*, 861 F.2d at 75. The Fourth Circuit also noted that "[t]he 'public interest' standard was added in 1984 in recognition of the specific weaknesses of the felony conviction criterion that made it difficult to reach the 'many violations involving controlled substances which are prescription drugs [but] are not punishable as felonies under state law.'" *Id.* (quoting S. Rep. No. 98-225 (1983)), *reprinted in* 1984 U.S.C.C.A.N. 3182, 3448-49). Allowing the Attorney General to utilize 21 U.S.C. § 824(a) to bar assisted suicide would improperly expand the CSA and its 1984 amendment beyond the intended criminal scope.

B. Court Decisions Uniformly Confirm That the Attorney General Must Defer to Medical Experts in Defining Legitimate Medical Use

The CSA does not provide a definition of "legitimate medical purpose" in its extensive definitions. Court decisions, however, uniformly confirm that the Attorney General must defer to expert medical judgment in determining what is and is not a legitimate medical use. The

Attorney General relies on two cases in his brief, *United States v. Rosenberg*, 515 F.2d 190 (9th Cir. 1975) and *United States v. Moore*, 423 U.S. 122 (1975) for the proposition that the CSA prohibits physicians from prescribing drugs except for legitimate medical purposes. Both cases demonstrate that expert medical judgment is required in order to determine what is and is not a legitimate medical purpose. In *Rosenberg*, the Ninth Circuit held that Dr. Rosenberg violated the CSA by prescribing Schedule II, III and IV controlled substances to patients he had not examined. *Rosenberg*, 515 F.2d at 192. These actions were violations of the CSA because expert medical testimony showed that they were outside the "usual course of his professional practice." *Id.* at 199.

Moore was relied on by the Attorney General, 66 Fed. Reg. 56,607, and by the OLC Opinion. Memorandum from Sheldon Bradshaw and Robert J. Delahanty, Office of Legal Counsel, Department of Justice, to the Attorney General 5-6 (June 27, 2001). In *Moore*, a physician prescribed methadone, a Schedule II controlled substance, in large quantities, charging by the pill, to patients not in detoxification or maintenance programs. *United States v. Moore*, 505 F.2d 426, 447 (D.C. Cir. 1974). What is noteworthy is that expert medical opinion was necessary to prove that this was not a legitimate medical practice and, therefore, violated the CSA. 505 F.2d at 447-48 (MacKinnon, J., dissenting). Reversing the Court of Appeals, this Court held that the physician could be liable for failing to use controlled substances if prescribed outside the boundaries of "professional practice". *Moore*, 423 U.S. at 142. The Court's statement here affirmed the lower court's finding that expert testimony was required to demonstrate that the defendant's use of a drug [under the

CSA] was not " . . . consistent with any method . . . that is accepted by the medical profession in this country [citation omitted]." 505 F.2d at 447. Thus, requiring expert medical testimony in a case predicated on violations of the CSA equates to determining legitimate medical use or purpose.

Other cases as well support the position that expert medical knowledge is required in all jurisdictions to determine legitimate medical use for purposes of proving that a physician has violated the CSA in the course of professional practice. "The general rule is that the propriety or impropriety of particular medical treatment can be established only by expert medical testimony." *Church v. Bloch*, 182 P.2d 241, 245 (Cal. 1947). *See also United States v. Boettjer*, 569 F.2d 1078, 1079 (9th Cir. 1978); *Farney v. Anderson*, 372 N.E.2d 151, 154 (Ill. 1978); *United States v. Tran Trong Cuong*, 18 F.3d 1132, 1137-38 (4th Cir. 1994); and *White v. United States*, 399 F.2d 813, 820 (8th Cir. 1968). Additionally, this required deference is consistent with the manner in which the law establishes what is and is not a legitimate medical use in contexts outside of the CSA. This Court, in *Davis v. Virginian Railway Co.*, 361 U.S. 354 (1960), articulated the standard of proof for malpractice as requiring two elements of evidence, " . . . evidence as to the recognized standard of care of the medical community in the particular kind of case, and a showing that the physician in question negligently departed from this standard in his treatment of the plaintiff." *Id.* at 357. Expert medical testimony is necessary to prove both elements. *See State v. Warden*, 813 P.2d 1146, 1151 (Utah 1991); *People v. Klvana*, 15 Cal. Rptr. 2d 512, 536 (Ct. App. 1992); and *Rudick v. Prineville Mem'l Hosp.*, 319 F.2d 764 (9th Cir. 1963). Expert medical knowledge, whether from outside experts or based on the expertise of

the physician members of the state medical boards, is also necessary to determine what is and is not a legitimate medical use in disciplinary hearings before state medical boards. *See Dotson v. Tex. State Bd. of Med. Exam'rs*, 612 S.W.2d 921, 923 (Tex. 1981); *Loffredo v. Sobol*, 600 N.Y.S.2d 507, 509-10 (App. Div. 1993); *McKay v. State Bd. of Med. Exam'rs*, 86 P.2d 232, 236 (Colo. 1938); *Smith v. Dep't of Registration*, 106 N.E.2d 722, 730-31 (Ill. 1952); and *Arlen v. State Med. Bd.*, 399 N.E.2d 1251, 1254 (Ohio 1980). The Texas Supreme Court in *Dotson* reversed a medical board's decision to suspend a doctor's license because there was no expert testimony to support the Board's factual conclusions. *Dotson*, 612 S.W.2d at 923.

Both the Attorney General and the DEA also appear to recognize the appropriateness of deferring to expert medical judgment. The DEA has recognized the need for experts to dictate and define "legitimate medical purpose." Patricia M. Goode, Chief of the Liaison and Policy Section of the DEA, told the Federation of State Medical Boards in a 1998 speech that, "[t]he CSA by design does not define "legitimate medical purpose" nor does it set forth standards of medical practice. These issues can only be defined by the medical community and its internal review process." Patricia M. Goode, *The Drug Enforcement Administration and Proposed Model Guidelines for the Use of Controlled Substances in Pain Management*, Address Before the Federation of State Medical Boards Symposium on Pain Management and State Regulatory Policy (Mar. 17, 1998) (*available at* http://www.medsch.wisc.edu/painpolicy/domestic/dea98.htm) (last visited April 17, 2005). The Attorney General referred to the American Medical Association's (AMA's) and the American Nurses Association's (ANA's) opinions opposing the Oregon Death with Dignity Act. Defendants' Memorandum In Support of Motion to

Dismiss at 34. However, it is important to note that the AMA's and ANA's views, themselves, do not settle the question of what is a legitimate medical use. The law recognizes that the practice of medicine is complex and that reasonable physicians may differ on what is legitimate and appropriate. There is room for disagreement among reasonable practitioners, as is reflected in the "respectable minority doctrine," which recognizes medical practices that are not the norm but are, nonetheless, legitimate in that they are acceptable and supported by a school of expert medical thought. *In re Williams*, 573 N.E.2d 638 (Ohio 1991); *Chumbler v. McClure*, 505 F.2d 489, 492 (6th Cir. 1974); and *Downer v. Veilleux*, 322 A.2d 82, 87 (Me. 1974).

More importantly, a majority of Oregon physicians believe that the Oregon Death with Dignity Act is consistent with legitimate medical practice. A survey from the *Journal of the American Medical Association* found that 51% of responding Oregon physicians (66% of practicing Oregon physicians) strongly supported or support the Death with Dignity Act and legalization of physician-assisted suicide. Linda Ganzini, M.D., et al., *Oregon Physicians' Attitudes About and Experience With End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, 285 JAMA 2363, 2365 (May 9, 2001). Supporters include Governor of Oregon, John A. Kitzhaber, M.D. Jim Barnett, *Kitzhaber Wants Direct Suicide Vote*, The Oregonian, March 1, 2000, at A03. According to studies, Oregonians and health care professionals also found assisted suicide being requested for sound and thoughtful reasons, without this method of terminating life being imposed upon patients. Br. *Amici Curiae* Healthlaw Professors, at 9-11, 14-15.

A national survey also established that 57% of U.S. physicians support physician-assisted suicide. Louis Finkelstein Institute for Religious and Social Studies, *Physician Assisted Suicide Survey* (2005), *available at* The Jewish Theological Seminary, http://www.jtsa.edu/research/finkelstein/surveys/pas.shtml. Even professional medical views recently adopted outside this country support not advocating against assisted suicide. "'Historic' change as opposition to euthanasia ends" (London) Daily Telegraph (July 5, 2005) (2005 WLNR 10348879). (Long-standing opposition among doctors to euthanasia dropped by the British Medical Association.).

II. THE REGULATION AND DETERMINATION OF LEGITIMATE MEDICAL PRACTICE IS RESERVED TO THE STATES

In Justice O'Connor's concurring opinion in *Glucksberg*, this Court recognized that the legality of physician-assisted suicide was an issue reserved to the "'laboratory' of the States in the first instance" and that states were undertaking extensive and serious evaluation of such issues. *Glucksberg*, 521 U.S. at 737 (quoting *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 292 (1990)). The Court noted as well, "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society." *Id.* at 735. Further, in past cases this Court has noted that the regulation and licensing of medical practices is generally reserved to the states under the United States Constitution. *See Linder v. United States*, 268 U.S. 5, 18 (1925); and *Younger v. Harris*, 401 U.S. 37, 44-45 (1971). In *Linder*, this Court reversed a physician's conviction under the Harrison Anti-Narcotic Law as outside the scope of the purpose of revenue collection. *Linder*, 268

U.S. at 22. This Court held that, "direct control of medical practice in the States is beyond the power of the federal government." *Id.* at 18. Allowing the Attorney General to dictate and define "legitimate medical purpose" would permit the federal government impermissibly to expand the scope of the CSA and exercise direct control over the practice of medicine in Oregon.

Although the CSA regulates the dispensing of medications under the Interstate Commerce Clause (U.S. Const. art. I, § 8, cl. 3), the Tenth Amendment (U.S. Const. amend. X), in addition to the stated purpose of the CSA, limits its power. As noted in the legislative history of the CSA, the State must be given deference to determine medical standards and licensing under its police power. *Oregon v. Ashcroft*, 368 F.3d at 1128. The dissenting judge in the Ninth Circuit did note that activities restricting prescription of controlled substances under the CSA are borne of Constitutional authority under the Interstate Commerce Clause. *Id.* at 1142. Such authority, however, does not always trump antecedent Amendments. *Seminole Tribe v. Florida*, 517 U.S. 44, 65 (1996). This Court, interpreting constitutional construction, stated that it could not accept "limitation of the principle embodied in the Eleventh Amendment through appeal to antecedent provisions of the Constitution." *Id.* (quoting *Pennsylvania v. Union Gas Co.*, 491 U.S. 1, 42 (1989) (Scalia, J., dissenting)). Similarly, the Tenth Amendment cannot be completely limited by the antecedent provisions of the Commerce Clause. *Id.* Though the scope of the Commerce Clause has been extensive and often used to interfere with intrastate police power, this power is not limitless. *United States v. Bird*, No. 95-20792, 1997 U.S. App. LEXIS 33988, at *23 n.10 (5th Cir. 1997). In *Bird*, The Fifth Circuit warned that, though "[t]he Tenth Amendment contains no substantive restriction on the legitimate exercise of Congress's

Commerce Clause authority . . . the Tenth Amendment plainly *does* confirm that the commerce power is *not* limitless, that hence such boundaries *do* exist, and that they *must not* be transgressed." *Id.* Our federal system precludes the Commerce Clause from becoming an excuse for the federal government to infringe upon state sovereignty and traditional state power. The Commerce Clause should not be utilized by one federal official to justify such a violation.

Allowing the Attorney General to define "legitimate medical purpose" and, in so doing, bar physician-assisted suicide, would be an unconstitutional invasion of the State of Oregon's police power. As *Linder* held, direct control of medical practice is outside the province of the federal government. *Linder*, 268 U.S. at 18. This Court took the same view when striking down a federal statute prohibiting gender-motivated crimes of violence. *United States v. Morrison*, 529 U.S. 598, 617-18 (2000). The majority in *Morrison* held that the Commerce Clause should not be utilized to usurp the proper police power of the states. *Id.* This Court stated, "[w]e accordingly reject the argument that Congress may regulate noneconomic, violent criminal conduct based solely on that conduct's aggregate effect on interstate commerce. The Constitution requires a distinction between what is truly national and what is truly local." *Id.* Oregon's Death with Dignity Act is both substantively and geographically a truly local law because its impact and operation do not survive outside Oregon's borders.

Regulation of the practice of medicine, like the suppression of violent crime, is part of the police power of the state. As noted by this Court in *Barsky v. Board of Regents*, 347 U.S. 442 (1954), "[i]t is elemental that a state

has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power." *Id.* at 449. The Attorney General's directive is an attempt to infringe this police power and thwart the state of Oregon's right to regulate health care as it sees fit. This Court should not allow the federal government to interfere with this state law.

Finally, this court's recent decision in *Gonzales v. Raich*, at 5, is consistent with our position. In that case, this court correctly determined that a California law could not avoid the CSA's classification of marijuana as a Schedule I substance. The Court stated that the CSA extended to regulation of drugs " . . . produced and consumed locally." *Gonzales*, ___ U.S. ___, 125 S.Ct. at 2201. In contrast, the current matter does not address whether a locally produced medication is governed by the CSA. Rather, it concerns whether the Attorney General may use his position to dictate how a drug regulated by the CSA can be used in medical practice by Oregon physicians. Such determinations are beyond the scope of the Attorney General's statutory power.

III. PROHIBITING THE USE OF NARCOTICS UNDER OREGON'S STATUTE WOULD NULLIFY THIS COURT'S DECISION IN *GLUCKSBERG*

Allowing the Attorney General to disregard states' rights here would invalidate this Court's decision in *Glucksberg*. If the Attorney General could prohibit the dispensing of narcotics for use in assisted suicide, he, alone, would essentially nullify this Court's determination that states could permit these practices. *Glucksberg*, 521 U.S. at 735.

In the present case, the dissent in the court below argued that the effect of the Attorney General's directive is minimized by the mere availability of other methods of assisting suicide. *Oregon v. Ashcroft*, 368 F.3d at 1135 (Wallace, J., dissenting). This reasoning gives short shrift to the issue and ignores the true effects of the Attorney General's rule. Utilization of controlled narcotics in hastening death may represent the most humane manner of effectuating a patient's directive of death by physician assistance. Kathy Faber-Langendoen & Jason H.T. Karlawish, *Should Assisted Suicide Be Only Physician Assisted?*, 132 Annals Internal Med., Mar. 21, 2000, at 482-87. Judge Wallace points to a law review article that suggests carbon monoxide poisoning as an alternative method of suicide. *Oregon v. Ashcroft*, 368 F.3d at 1135. However, this suggestion ignores the fact that this toxin is not used by any physicians for any legitimate medical purpose. Armin Ernst, M.D. and Joseph D. Zibrak, M.D., *Current Concepts: Carbon Monoxide Poisoning*, 399 New Eng. J. Med., Nov. 26, 1998, at 1603-1608. Carbon monoxide is not an FDA-approved medication and has no current bona fide use in the medical field. Physician inexperience with carbon monoxide administration may result in failed suicide attempts. Faber-Langendoen & Karlawish, *supra*, at 482-87. Additionally, carbon monoxide poisonings, in contrast to narcotic overdoses, may result in significant pain and suffering during a patient's death. Ernst & Zibrak, *supra*, at 1603-1608. (noting significant acute symptoms from carbon monoxide poisoning including headache, nausea, shortness of breath, chest pain and abdominal pain). Failed attempts at poisoning may also result in significant neurological deficits. Up to 30% of surviving carbon monoxide poisoning victims experience a neuropsychiatric syndrome up to 240 days after poisoning.

Id. Symptoms may include psychosis, dementia, personality change, incontinence and parkinsonism. *Id.* As a result, and despite Judge Wallace's suggestions to the contrary, this form of assisted suicide is not an effective substitute for assisted suicide with controlled substances. It would be reckless for this Court to approve all manners of terminating life as the practice of medicine. Allowing all methods of poisoning to achieve such a result within the ambit of medical practice would also set a broad and dangerous precedent that may damage the medical profession.

Narcotics remain integral to providing sedation and pain control in current forms of physician-assisted suicide. Faber-Langendoen & Karlawish, *supra*, at 482-87. Enforcement of the Attorney General's directive may completely prohibit the administration of these controlled substances, causing a painful and angst-ridden demise. This prohibition directly infringes on liberty interests implied in the *Glucksberg* ruling. As Justice Stevens pointed out in his concurring opinion, "[a]voiding intolerable pain and the indignity of living one's final days incapacitated and in agony is certainly 'at the heart of [the] liberty . . . to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.'" *Glucksberg*, 521 U.S. at 745. (Stevens, J., concurring) (quoting *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 851 (1992)). As a result, the Attorney General's restricting the states' ability to allow a dignified and pain-free death unconstitutionally violates the liberty interests of an entire class of Oregonians.

IV. ALLOWING POLITICAL PREFERENCE TO DICTATE LEGITIMATE MEDICAL PRACTICE WOULD HARM THE MEDICAL PROFESSION AND THE PRACTICE OF MEDICINE

Allowing politically-appointed administrators to dictate proper medical practices would harm the integrity and stability of the medical field. As noted in *Glucksberg*, the integrity of the practice of medicine is important and, "the state also has an interest in protecting the integrity and ethics of the medical profession." *Id.* at 731. Allowing the standard of care to be subject to mercurial political whim could have devastating consequences on this profession.

As noted in the Ninth Circuit's opinion, Attorney General Janet Reno refused to declare assisted suicide as a violation of the CSA. *Oregon v. Ashcroft*, 368 F.3d at 1123. Instead, Attorney General Reno made it clear that, "the CSA was not 'intended to displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice.'" *Id.* A subsequent political regime change reversed this position. If this Court were to uphold such a reversal, the determination of "legitimate medical practice" would face continuous revision depending on the prevailing politics in the executive branch. This uncertainty was noted by the dissent in the Ninth Circuit who stated, "[a] change in presidential administrations or a shift in the current President or Attorney General's perspective might precipitate the Ashcroft Directive's rescission." *Id.* at 1148. This uncertainty in the standards of practice cannot be allowed.

Medical practice must be determined by objective standards of care and clinically-based studies. Judicially,

"[w]hat constitutes bona fide medical practice must be determined upon consideration of evidence and attending circumstances." *Linder*, 268 U.S. at 18. Scientific journals, specialty boards, and peer review must dictate standards of practice, not partisan politicians. It is in recognition of the need for this expertise that every state's legislature has ceded part of its police power to expert medical boards and those with requisite medical expertise. Additionally, recognition of this expertise has prompted state courts to afford great discretion to board decisions. *Ramirez v. Tex. Bd. of Med. Exam'rs*, 995 S.W.2d 915, 919 (Tex. App. 1999). Allowing the will of politically-motivated officials to circumvent proper oversight and regulation by health care and medical professionals would serve to undermine the medical profession.

CONCLUSION

In conclusion, the plain language of the CSA, its accompanying legislative history, and the cases interpreting its provisions make it clear that determining a legitimate medical purpose is a matter of expert medical judgment, not a political decision by the Attorney General. The statutory scheme requires the Attorney General to defer to the Secretary of Health and Human Services, informed by appropriate and sound medical expertise, and to not act with a Draconian hand as he has chosen to do by issuing the directive at issue in this case. Moreover, as Justice O'Connor wisely observed in this Court's *Glucksberg* decision, the states are the proper laboratories to experiment with adjusting the scope of acceptable medical practice. The State of Oregon has done so with its Death

With Dignity Act. Its decision should be followed and respected by this Court.

For the foregoing reasons, the judgment of the Ninth Circuit should be affirmed.

Respectfully submitted,

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